OHIC - April 2011
Large and Small Group Rate Factor Review
Survey: Provider Contracting Practices.

Background

The Health Insurance Advisory Council of the Office of the Health Insurance Commissioner has promulgated Affordability Standards for Commercial Health Insurers in Rhode Island:

> *Health plans will improve the affordability of health care in Rhode Island by focusing their efforts upon provider payment reform, beginning with primary care. Achievement of this goal will not add to overall medical spend in the short-term, and is expected to produce savings thereafter. Specific areas of focus in support of this goal are as follows:*
>
> 1. *Expand and improve the primary care infrastructure in the state -- with limitations on ability to pass on cost in premiums*
> 2. *Spread Adoption of the "Chronic Care Model" Medical Home*
> 3. *Standardize electronic medical record (EMR) incentives*
> 4. *Work toward comprehensive payment reform across the delivery system*

To support standard four, OHIC has issued in connection with its review of 2010 large and small group rate factors six conditions for health insurer contracts with hospitals in Rhode Island, to be implemented by health insurers upon contract execution, renewal or extension (see OHIC's July 2010 Rate Factor Decision – Additional Conditions, for the complete text of the conditions):

1. Utilize unit of service payment methodologies for both inpatient and hospital outpatient services that realign payment to provide incentives for efficient use of health services, and are derived from nationally utilized payment practices other than fee for service.
2. Limit average annual effective rates of price increase for both inpatient and outpatient services to a weighted amount equal to or less than the Centers for Medicare and Medicaid Services (CMS) National Prospective Payment System Hospital Input Price Index ("Index"), for all contractual and optional years covered by the contract
3. Provide the opportunity for hospitals to increase their total annual revenue for commercially insured enrollment under the contract by at least additional two percentage points over the previous contract year by improving or attaining mutually agreed-to performance levels for no less than three nationally-accepted clinical quality, service quality or efficiency-based measures.
4. Include terms that define the parties' mutual obligations for greater administrative efficiencies,
5. Include terms that promote and measure improved clinical communications between the hospital and each patient/member's designated primary care

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physician, specialist physicians, long term care facility, or other providers.

6. Include terms that explicitly relinquish the right of either party to contest the public release of the any and all of these five specific terms by state officials or the participating parties to the agreement.

The purpose of this survey is to assess the pace and nature of provider payment reform in Rhode Island, given a baseline survey last year and the Advisory Council's Affordability Standards, and to consider the information survey responses in connection with OHIC's 2011 Rate Factor Decision.

Directions:

1. Please fill out all parts of survey.
2. As no providers are identified and no financial details are solicited, none of this information will be considered proprietary or confidential.
3. Any contract excerpts provided will be summarized for review.
4. Please contact the Office of the Health Insurance Commissioner with any questions.

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General comment:

Tufts Health Plan has a long standing commitment to investment in payer-provider incentive alignment, and we maintain hospital and physician incentive programs that apply to the vast majority of our network providers. As a relatively new entrant into the RI market, we are at an early stage of incorporating incentive mechanisms into our RI provider contracts. Provider incentive will be a key component of our contracting strategy as we grow our presence in the state of RI.

Tufts Health Plan requests that the information provided in response to this survey be deemed to constitute "trade secrets" within the meaning of the term in section 38-2-2(4)(i)(B) of the Rhode Island General Laws. We have included a footer stating "THIS INFORMATION IS A TRADE SECRET AND MAY NOT BE DISCLOSED TO THIRD PARTIES WITHOUT TUFTS HEALTH PLAN'S PERMISSION".

Finally, due to the questionable reliability of certain information provided in our responses, which is explained in further detail below, it is Tufts Health Plan's expectation and understanding that the information provided in this Provider Survey will not be used or considered in OHIC's review of Tufts Health Plan's rates.

Part 1. Hospital Inpatient Services

- **Please fill out one row in the chart below for <u>each</u> general service institution (no specialty care, no rehab) with whom you contract in RI.**
- **Institution means hospital system if all contractual terms other than $ amounts apply identically across all inpatient facilities in the contract.**
- **Incentives refer to activities or measures resulting in additional payments by the insurer.**

Institution/ System	Duration of Current Contract since inception or last renewal, whichever is later (years)	Unit of Payment for Services (check all that apply)	Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments	Are there Quality or Customer Service Incentives in Contract (y/n)[1]?	Utilization Incentives in Contract: (check all that apply)	Does this contract comply with OHIC's July 2010 Rate Factor Decision – Additional Conditions?[2]	Comments
1	3 years	x DRG x Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	No	Yes If yes - %of total payments for inpatient services in CY 2010 spent on quality incentive payments. [3] 0~2%	__ admission reductions x day reductions __Others (please specify) Incentive payments 0~3%_____	N/A (Contract has not been renegotiated)	
2	3 years	x DRG x Per Diem	Yes to additional outlier provision	Yes	__ admission reductions __ day reductions	N/A	

[1] Examples include supplemental payments beyond base fees for Bridges to Excellence Measure, Medicare Compare measures, HIT adoption, or customer satisfaction measures.
[2] Attach analysis and relevant documentation from contracts to demonstrate compliance status.
[3] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

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Survey: Provider Contracting Practices (cont'd)

Institution/ System	Duration of Current Contract since inception or last renewal, whichever is later (years)	Unit of Payment for Services (check all that apply)	Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments	Are there Quality or Customer Service Incentives in Contract (y/n)[1]?	Utilization Incentives in Contract: (check all that apply)	Does this contract comply with OHIC's July 2010 Rate Factor Decision – Additional Conditions?[2]	Comments
		__% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)		If yes - %of total payments for inpatient services in CY 2010 spent on quality incentive payments. 0.5~1.0%	__Others (please specify)	(Contract has not been renegotiated)	
3	3 years	__DRG __Per Diem x % of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	No	Yes If yes - %of total payments for inpatient services in CY 2010 spent on quality incentive payments. 0.1~0.5%	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	
4	3 years	__DRG x Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	Yes to additional outlier provision	No If yes - %of total payments for inpatient services in CY 2010 spent on quality incentive payments. _____	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	
5	2 years	__DRG __Per Diem x % of Charges __ Bundled	No	No If yes - %of total payments for inpatient services in CY	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	

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Survey: Provider Contracting Practices (cont'd)

Institution/ System	Duration of Current Contract since inception or last renewal, whichever is later (years)	Unit of Payment for Services (check all that apply)	Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments	Are there Quality or Customer Service Incentives in Contract (y/n)[1]?	Utilization Incentives in Contract: (check all that apply)	Does this contract comply with OHIC's July 2010 Rate Factor Decision – Additional Conditions?[2]	Comments
		Services __ Capitation or other budgeting __Others (please specify)		2010 spent on quality incentive payments. _____			
6	1 year	__DRG __Per Diem _x_% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	No	No If yes - %of total payments for inpatient services in CY 2010 spent on quality incentive payments. _____	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	
7	2 years	__DRG _x_Per Diem __% of Charges __ Bundled Services __ Capitation or other budgeting __Others (please specify)	Yes to additional outlier provision	No If yes - %of total payments for inpatient services in CY 2010 spent on quality incentive payments. _____	__ admission reductions __ day reductions __Others (please specify)	N/A (Contract has not been renegotiated)	
8	1 year	__DRG _x_Per Diem __% of Charges __ Bundled Services __ Capitation or	Yes to additional outlier provision	Yes If yes - %of total payments for inpatient services in CY 2010 spent on quality incentive payments.	__ admission reductions __ day reductions __Others (please specify)	Yes, see attached.	

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Survey: Provider Contracting Practices (cont'd)

Institution/ System	Duration of Current Contract since inception or last renewal, whichever is later (years)	Unit of Payment for Services (check all that apply)	Does Contract have provision for additional outlier payments and/or severity adjusters (y/n) and any comments	Are there Quality or Customer Service Incentives in Contract (y/n)[1]?	Utilization Incentives in Contract: (check all that apply)	Does this contract comply with OHIC's July 2010 Rate Factor Decision – Additional Conditions?[2]	Comments
		other budgeting __Others (please specify)		1%			

Additional Questions for Hospital Inpatient Services

1. List the five most common areas of quality and service incentives in your company's inpatient contracts:
   (These measures apply to our hospital contracts that combine inpatient and outpatient services.)
   i. Joint Commission measures (e.g., AMI, CHF, pneumonia)
   ii. Leapfrog measures (e.g., CPOD, ICU staffing)
   iii.Prevention of "Never Events"
   iv.Surgical infection rates
   v. Readmission rates
2. Estimated Percent of total payments to RI Hospitals for inpatient services in CY 2010 spent on quality incentive payments. 0.5~1%

3. Estimated Percent of total payments to RI Hospitals for inpatient services in CY 2010 paid through units of service based on efficient resource use (i.e DRG, Capitation, Bundled Service or partial/global budgeting): <5%

4. Estimated Payments in first six months of CY 2010 for Inpatient Services to Hospitals as % of what Medicare would have paid for similar set. of services: See comment _____ (add comments or caveats)

   For inpatient services Tufts Health Plan does not currently have the technical capability to benchmark to Medicare IPPS reimbursement. Conducting such analysis would require incremental time, resources and technical capabilities. Benchmarking Tufts Health Plan inpatient payments to Medicare IPPS may yield volatile and potentially unreliable results due to a) differences in reimbursement methodology (Tufts Health Plan reimburses the majority of inpatient claims on either a Per Diem or Percent of Charge basis); b) our relatively small volume of business in Rhode Island; c) mix of services; and d) chargemaster levels to some of the hospitals in Rhode Island. Additionally, it is our belief that a Medicare comparison for some hospitals that perform very specific services, like Obstetrics, will not result in a comparison that is useful and may lead to unintended and/or misinterpreted conclusions.

Other Comments on Quality/Efficiency Incentives in Hospital Inpatient Contracting:

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Part 2. Hospital Outpatient Services

- **Please fill out one row in the chart below for each general service institution (no specialty care, no rehab) with whom you contract in RI.**
- **Institution means hospital system if all contractual terms other than dollar amounts apply identically across all inpatient facilities in the contract.**
- **Outpatient Services include any services not involving an admission and covered under the contract with the institution.**

Institution/ System	Unit of Payment for Outpatient Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[4]?	Utilization Incentives in Contract: (check all that apply)	Comments
1	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	Yes If yes - %of total payments for inpatient services in CY 2010 spent on quality incentive payments. [5] 0~2%	__ Visit/Volume Reduction __ Others (please specify)	
2	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	Yes If yes - %of total payments for inpatient services in CY 2010 spent on quality incentive payments. 0.5~1.0%	__ Visit/Volume Reduction __ Others (please specify)	
3	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	Yes If yes - %of total payments for inpatient services in CY 2010 spent on quality incentive payments. 0.1~0.5%	__ Visit/Volume Reduction __ Others (please specify)	
4	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - %of total payments for inpatient services in CY 2010 spent on quality	__ Visit/Volume Reduction __ Others (please specify)	

[4] Examples include supplemental payments beyond base fees for structural changes such as HIT, process measures or customer satisfaction.
[5] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

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Institution/ System	Unit of Payment for Outpatient Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[4]?	Utilization Incentives in Contract: (check all that apply)	Comments
		incentive payments. _____		
5	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - %of total payments for inpatient services in CY 2010 spent on quality incentive payments. _____	__ Visit/Volume Reduction __ Others (please specify)	
6	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - %of total payments for inpatient services in CY 2010 spent on quality incentive payments. _____	__ Visit/Volume Reduction __ Others (please specify)	
7	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - %of total payments for inpatient services in CY 2010 spent on quality incentive payments. _____	__ Visit/Volume Reduction __ Others (please specify)	
8	x Procedure-based methodology – using plan, provider or industry coding. . __APC Code __Other (please specify)	No If yes - %of total payments for inpatient services in CY 2010 spent on quality incentive payments. _____	__ Visit/Volume Reduction __ Others (please specify)	

Additional Questions for Hospital Outpatient Services

1. List the five most common areas of quality and service incentives in your company's hospital outpatient contracts:
   These measures apply to our hospital contracts that combine inpatient and outpatient services.
   i. Joint Commission measures (e.g., AMI, CHF, pneumonia)
   ii. Leapfrog measures (e.g., CPOD, ICU staffing)
   iii.Prevention of "Never Events"
   iv.Surgical infection rates

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v. Readmission rates

2. Percent of total payments to RI Hospitals for outpatient services in CY 2010 spent on quality incentive payments. __0.5~1%_____
3. Percent of total payments to RI Hospitals for inpatient services in CY 2010 paid through units of service based on efficient resource use (i.e APC, Bundled Services or partial/global budgeting):___n/a_____

Redacted at request of The Carrier.

4. Estimated Payments in first six months of CY 2010 for Outpatient Services to Hospitals as % of what Medicare would have paid for similar set. of services: [redacted]% (i.e. [redacted]% over Medicare reimbursement) (add comments or caveats)

For Outpatient Services, Tufts Health Plan has the technical capabilities to perform the required benchmarking analysis to Medicare; however, we have concerns about the confidence level in the accuracy of the supplied benchmark. Our concerns are due to a) the allowed reimbursement at a claim level was compared to fee information obtained from OPPS and CMS ancillary schedules such as Clinical Lab, DME etc.; b) we are not able to reprocess our claims through an OPPS Grouper and were limited to a line level reprice based on OPPS/Ancillary fees which means that exact Medicare reimbursement can only be approximated; c) Procedures that do not have a fee on OPPS/Ancillary schedules, or are billed in a different manner to Medicare (e.g., observation) were dropped from the analysis.

Additionally, Tufts Health Plan has concerns that the results may be skewed due to a few high-volume hospitals and the large number of providers reimbursed on a percent of charges basis – factors that may distort the data due to particular mix of services and chargemaster levels of PAF providers. Based on the concerns listed above it is our belief that a Medicare comparison might not result in a benchmark that is useful and could lead to unintended and/or misinterpreted conclusions that if made public could impact certain contract negotiations by putting upward pressure on unit costs.

Other Comments on Quality/Efficiency Incentives in Hospital Outpatient Contracting:

Part 3: Professional Groups

- **"Professional Groups" is defined as non institutional/non facility groups with a valid contract and a single tax id number.**
- **Please provide information for the top 10 groups (measured by $ paid in 2010), filling in one row per group (10 rows in the table total).**

Group	Specialty Type	Unit of Payment for Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[6]?	Utilization Incentives in Contract: (check all that apply)	Comments
1	Multi-	x Procedure-based	No	__ Visit/Volume Reduction	

[6] Examples include supplemental payments beyond base fees for EMR adoption, structural changes, accreditation, process measures or patient satisfaction.

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Group	Specialty Type	Unit of Payment for Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[6]?	Utilization Incentives in Contract: (check all that apply)	Comments
	specialty	methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	If yes - %of total payments for inpatient services in CY 2010 spent on quality incentive payments. [7] _____	__use of ancillary/referred services __ use of diagnostic tests __ over all efficiency of care __ use of pharmacy services _ Others (please specify)	
2	Multi-specialty	_X_ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - %of total payments for inpatient services in CY 2010 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ over all efficiency of care __ use of pharmacy services __ Others (please specify)	
3	Multi-specialty	_ X _ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	Yes If yes - %of total payments for inpatient services in CY 2010 spent on quality incentive payments. _~1%_____	_x_ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ over all efficiency of care __ use of pharmacy services __ Others (please specify)	
4	Sub - Specialty	_ X _ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - %of total payments for inpatient services in CY 2010 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ over all efficiency of care __ use of pharmacy services __ Others (please specify)	
5	Primary Care	_ X _ Procedure-based methodology – using CPT, plan, provider or other coding. .	No	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests	

[7] % for Incentive Payments plus % for Services = 100%. Incentive payments not specified for inpatient or outpatient should be classified as inpatient.

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Group	Specialty Type	Unit of Payment for Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[6]?	Utilization Incentives in Contract: (check all that apply)	Comments
		__APC Code __ Full/ Partial Capitation __Other (please specify)	If yes - %of total payments for inpatient services in CY 2010 spent on quality incentive payments. _____	__ over all efficiency of care __ use of pharmacy services __ Others (please specify)	
6	Primary Care	_ X _ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	Yes If yes - %of total payments for inpatient services in CY 2010 spent on quality incentive payments. 0~5%	x Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ over all efficiency of care x use of pharmacy services x Others (please specify)	Quality/Member Satisfaction
7	Sub - Specialty	_ X _ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	Yes If yes - %of total payments for inpatient services in CY 2010 spent on quality incentive payments. ~5%	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ over all efficiency of care x use of pharmacy services __ Others (please specify)	Generic prescription
8	Sub - Specialty	_ X _ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - %of total payments for inpatient services in CY 2010 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ over all efficiency of care __ use of pharmacy services __ Others (please specify)	
9	Multi-specialty	_ X _ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - %of total payments for inpatient services in CY 2010 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ over all efficiency of care __ use of pharmacy services __ Others (please specify)	

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Group	Specialty Type	Unit of Payment for Services (check all that apply)	Are there Quality or Customer Service Incentives in Contract (y/n)[6]?	Utilization Incentives in Contract: (check all that apply)	Comments
10	Multi-specialty	_ X _ Procedure-based methodology – using CPT, plan, provider or other coding. . __APC Code __ Full/ Partial Capitation __Other (please specify)	No If yes - %of total payments for inpatient services in CY 2010 spent on quality incentive payments. _____	__ Visit/Volume Reduction __use of ancillary/referred services __ use of diagnostic tests __ over all efficiency of care __ use of pharmacy services __ Others (please specify)	

Additional Questions for Professional Groups

1. List the five most common areas of quality and service incentives in your company's professional group contracts:
   i. HEDIS (diabetes, breast cancer screening, colonoscopy, etc.)
   ii. HCHAPS
   iii. EMR adoption
   iv. Inpatient and ER use
   v. Rx Management

2. Percent of total payments to these ten professional groups in CY 2010 spent on quality incentive payments. ___<1%_____

3. Percent of total payments to these ten professional groups in CY 2010 paid through units of service based on efficient resource use (i.e APC, Bundled Services or partial/global budgeting): ___n/a_____

Redacted at request of The Carrier

4. Estimated Payments in first six months of CY 2010 for Professional Group Services as % of what Medicare would have paid for similar set. of services: [redacted]% (i.e. [redacted]% over Medicare reimbursement) (add comments or caveats)

   The analysis was conducted using a claim line level comparison between allowed reimbursement and Medicare fee information obtained from RBRVS tables as well as Medicare ancillary schedules such as clinical lab, DME etc. Anesthesia services were also included. Procedures that Medicare does not reimburse but supplies RVU information for, such as preventive medicine and consults codes, are included at the RVU level rate for the Medicare comparison. Claims lines that do not have RBRVS/Ancillary schedule information were dropped from the analysis.

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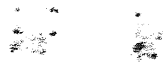
Additionally, Tufts Health Plan has concerns that the results may be skewed due to particular mix of services for providers. Based on the concerns listed above it is our belief that a Medicare comparison might not result in a benchmark that is useful and could lead to unintended and/or misinterpreted conclusions that if made public could impact certain contract negotiations by putting upward pressure on unit costs.

Other Comments on Quality/Efficiency Incentives in Professional Group Contracting:



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Selected Contract Sections Showing Compliance To OHIC Conditions

Effective for dates of service on or after January 1, 2011

Office of the Health Insurance Commissioner Conditions

Unit Cost: Aggregate unit cost increase for CY 2011 yields 2.1%.

Pay-For-Performance: A bonus payment of 2% based on 2011 claims volume at the Hospital for Tufts Health Plan members is available for the Hospital to earn based upon quality and/or efficiency measures that will be on mutually agreed to by both parties by 03/31/2011.

Case Rates: In the event Tufts Health Plan membership grows beyond 50,000 members during 2011 parties agree to meet to discuss the potential to transition to efficiency based payment methodologies (e.g., DRG, APC) in a manner that does not increase medical or administrative costs to either party and is mutually agreeable.

Administrative Efficiency: Tufts Health Plan agrees to assign a Contract Specialist to provide ongoing contract related support through the term of the agreement to help mitigate contract related issues.

The Hospital agrees to work with and communicate issues to the Contract Specialist on an ongoing basis and work in good faith to resolve contract related issues in a timely manner.

Communication: During calendar year 2011 parties agree to formalize clinical communication that promotes and measures improved clinical communications between the hospital and each patient/member's designated primary care physician, specialist physicians, long term care facility, or other providers.

Public Release of Contract Terms: Parties agree to allow the public release of terms outlined in this agreement if compelled by State regulatory authorities.

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